Request for Proposals (RFP)

Issue Date: August 11, 2004 RFP# 601-611-45417-05-HRY

Title: **HIV Prevention Targeting High Risk Youth and Adults**

Issuing Agency: Virginia Department of Health
Office of Purchasing & General Services
For Division of HIV, STD, and Pharmacy Services
P.O. Box 2448, Room 1214
Richmond, Virginia 23218-2448

Initial Period of Contract: One Year January 1, 2005 - December 31, 2005
(Renewable for three (3) one-year periods)

Sealed Proposals will be received until **3:00 p.m., September 22, 2004** by the Virginia Department of Health Office of Purchasing and General Services (OPGS) located on the 12th Floor, Room 1214, James Madison Building, 109 Governor Street, Richmond, Virginia 23219. To be considered, all proposals must be received at this specific location on or before the date and hour stipulated. Offerors should pay particular attention to ensure that the proposal is properly addressed. The state is not responsible if the proposal does not reach the specific destination by the appointed time. Proposals received after the date and hour designated are automatically disqualified and will not be considered. The official time used in the receipt of responses is that time on the clock or automatic time stamp machine in the Office of Purchasing and General Services.

The response may be sent via U.S. Mail to the Post Office Box address listed above provided that it is submitted in adequate time to allow for delivery to the specific office location, Room 1214, James Madison Building, 109 Governor Street, Richmond, Virginia 23219. Offerors are responsible for assuring timely receipt of the proposal at the specific office location and should make allowance for the possibility of an untoward event.

The safest way to insure the proposal is delivered on time, especially if it is submitted within the last seven (7) days prior to the due date, is to deliver it in person. The alternative is to use a commercial delivery service such as FedEx or UPS, or the U.S. Post Office Express Mail Service. If any of these services are used, send the proposal to the following address:

VIRGINIA DEPARTMENT OF HEALTH
JAMES MADISON BUILDING, ROOM 1214
109 GOVERNOR STREET
RICHMOND, VA 23219

If the proposal is delivered in person, use the first floor entrance, East Grace and Governor Streets.

Note: This Public Body does not discriminate against faith-based organizations in accordance with the Code of Virginia, Section 11-35.1 or against a bidder or offeror because of race, religion, color, sex, national origin, age, disability, or any other basis prohibited by state law relating to discrimination in employment.

All inquiries for program specific information should be directed to Kasey Kelly, who may be reached by calling (804) 864-8013, fax (804) 864-8053 or e-mail kasey.kelly@vdh.virginia.gov . All other inquiries should be directed to Debbie Vergara who may be reached at (804) 864-7524, Fax (804) 864-7533, e-mail debbie.vergara@vdh.virginia.gov .

In compliance with this request for proposals and to all the conditions imposed therein and hereby incorporated by reference, the undersigned agrees to furnish the goods/services in accordance with the attached signed proposal or as mutually agreed upon by subsequent negotiation.

Date: _____ By: _____
Signature – Authorized Representative

Title: _____
Of Above Authorized Representative

Name and Address of Firm or Organization:

_____

_____

_____

_____

Telephone: (____) _____

Fax: (_____) _____

Email: _____

FIN/FEI#: _____

OPTIONAL PRE-PROPOSAL CONFERENCE: A pre-proposal conferences will be held in Richmond on August 24 at 11:00 a.m. The conference may be accessed by audio conference call. Questions may be faxed prior to the conference if desired. **See page 12 for additional information.

I. Purpose:

The purpose of this Request for Proposals (RFP) is to establish contracts through competitive negotiations with qualified contractors for the purchase of HIV prevention interventions for high-risk youth and adults by the Virginia Department of Health.

II. Background:

A total of $350,000 is available. Multiple awards will be made. Previous awards ranged from $25,000 - $65,000.

These funds are intended to address priority populations identified by the Virginia HIC Community Planning Committee and to address gaps in services among high-risk populations that are not being targeted through other HIV/STD grant programs.

It is the policy of the Commonwealth of Virginia to contribute to the establishment, preservation, and strengthening of small business and businesses owned by women and minorities and to encourage their participation in state procurement activities. The Commonwealth encourages contractors to provide for the participation of small business and businesses owned by women and minorities through partnerships, joint ventures, subcontracts, or other contractual opportunities.

III. Scope of Service:

1. The contractor should provide interventions which are shown to be effective in reducing risk behaviors or maintaining safe behaviors among targeted populations which include high risk youth and adults. Interventions should address gaps in services or expand on services rather than duplicate existing programs in Virginia.

   Interventions conducted should be those prioritized by the Virginia HIV Community Planning Committee (Attachment 1). The contractors should address these or other needs and/or propose alternative interventions provided sufficient justification is provided in their needs assessment and approved by VDH (See section IV. Proposal Preparation and Submission Requirements). Innovative, untried methods may also be proposed provided they are based on scientific theories or models, which could be expected to work for the targeted population.

   Contractors are encouraged to use curricula with a theoretical or scientific basis.Use of interventions, when appropriate, from the *Diffusion of Effective Behavioral Interventions* (DEBI) or those found in the CDC *Compendium of HIV Prevention Interventions with Evidence of Effectiveness* are strongly encouraged. For additional information please see www.effectiveinterventions.org .

2. The contractors should develop interventions with the input of the targeted populations and services provided should be by trained staff members or volunteers who are culturally competent and linguistically appropriate.

3. Contractors should use the Suggested Taxonomy of Interventions (Attachment 2) in defining their proposed programs and services to be performed. Contractors should adhere to VDH Prevention Education Standards (Attachment 3).

4. Contractors shall provide services to one or more of the following targeted populations. Priority populations, their subpopulations and accompanying descriptions can be found in the Virginia HIV Community Planning Committee 2003 Comprehensive Plan Target Populations (Attachment 4):
(See points in the evaluation of award criteria that will be awarded to reflect populations selected.

Population 1: High Risk Youth:

Contractors should provide HIV prevention education to youth at increased risk for HIV infection.

High risk youth may be defined as homeless, runaway, throw-away, out-of-school, sexual minority, and youth offenders in Virginia's learning centers or juvenile detention or street youth. Youth are defined as persons under the age of 25.

Contractors are encouraged to work with Virginia Department of Juvenile Justice (DJJ) Facilities. See Enclosure 1 for the DJJ facilities list.

Population 2: High Risk Adults

Contractors should provide HIV prevention education to one or more of the adult populations at increased risk for HIV infection listed below. Adults are defined as persons over the age of 25.

A. Injection Drug Users (IDUs):

Distribution of needles and/or syringes, lobbying and direct medical care shall not be supported with these funds.

B. Heterosexual Adults:

Contractors should provide HIV prevention to heterosexual adults at increased risk for HIV infection.

At Risk may be defined as someone who is sexually active or uses injecting drugs in a high prevalence setting.

At High Risk may be defined as someone who has had unprotected in a high prevalence setting or with a person who is living with HIV.

At Very High Risk may be defined as someone who (within the past six months) has:

- Had unprotected sex with a person who is living with HIV.
- Had unprotected sex in exchange for money or drugs
- Had multiple (greater than five) or anonymous unprotected sex or needle-sharing partners or,
- Been diagnosed with a sexually transmitted infection (STI)

A High prevalence setting may be defined as a geographic location or community with an HIV seroprevalence greater than or equal to one percent

C. Incarcerated

If contractors elect to target incarcerated adults, services should be provided to institutions not currently being served with such programs.

D. Persons Living with HIV/AIDS

Contractors should provide primary prevention to Persons Living with HIV/AIDS.

Primary Prevention for persons living with HIV/AIDS may be incorporated within any of the targeted populations.

E. Other

5. Any educational materials (pamphlets, posters, curricula, videos etc.) proposed to be used, developed or purchased shall be submitted to the VDH AIDS Materials Review Panel for approval. VDH convenes the Review Panel in order to comply with directives from the Centers for Disease Control and Prevention. The content of such materials will be reviewed and approved for scientific accuracy and shall support the contracted scope of services while assuring appropriateness of the message for the targeted population including their culture and language.

6. Contractors shall attend all quarterly contractor meetings convened by the Virginia Department of Health.

7. Contractors shall participate in a statewide system of evaluation to measure program outcomes including submission of annual intervention plans, quarterly intervention worksheets and other documentation. This information will be submitted through the CDC Project Evaluation Monitoring System (PEMS) web-based system when it becomes available. Please see attachment 5 for PEMS technical requirements.

8. Contractors shall participate in disseminating information for special events such as National HIV Testing Day and World AIDS Day.

9. Contractors and subcontractors that can be deemed to be covered entities under the Health Insurance Portability and Accountability Act (HIPAA) will comply with all regulations relevant to HIPAA.

IV. Reporting:

A. Quarterly reports shall be submitted by the 15th of the month following each quarter (April 15, July 15, October 15, and January 15) to:

Casey W. Riley, Director
Division of HIV/STD
P. O. Box 2448, Room 326
Richmond, Virginia 23218-2448

Report shall be submitted in the following format:

1. Highlights
2. Restatement of each objective
3. Activities undertaken to fulfill that objective
4. Problems and barriers encountered
5. Other related activities
6. Supporting documentation

One original shall be submitted by mail only. The Division will not accept fax or email copies of reports.

B. Requests for budget or work plan modifications must be made in writing at least 30 days prior to the end of the contract. VDH shall be responsible for determining the legitimacy of the extenuating circumstances and the acceptability of revised plans or objectives.

C. Failure to attain objectives may impact payment of monies requested by the contractor. However, in an effort not to penalize innovative efforts, payment shall be prorated according to the degree of attainment and legitimate efforts of the contractor and not solely by success or failure of an innovative project. Such decisions shall be

at sole discretion of VDH.

D. Time and effort (T&E) records for each employee paid in full or in part through this contract must be kept on file at the contractor's site and made available upon request.

IV. Virginia Department of Health Activities:

A. VDH will hold an orientation session for new contractors to provide information on contract management, fiscal and reporting requirements, and other contractual procedures.

B. VDH will review and provide feedback and recommendations on contractor's quarterly progress reports.

C. VDH will provide technical assistance to contractors.

D. VDH will make at least one site visit to observe interventions. Records and forms will be reviewed for completeness and accuracy. Site visits may be announced or unannounced.

V. Proposal Preparation and Submission Requirements:

A. General requirements:

1. **RFP Response:** In order to be considered for selection, Offerors must submit a complete response to this RFP. One (1) original and five (5) copies of the proposal shall be submitted. Proposals shall be submitted in accordance with instruction on the first page of this RFP.

2. **Proposal Preparation**:

a. Proposal shall be signed by an authorized representative of the offeror. All information requested should be submitted. Failure to submit all information requested may result in the purchasing agency requiring prompt submission of missing information and or giving a lowered evaluation of the proposal. Proposals which are substantially incomplete or lack key information may be rejected by the purchasing agency. Mandatory requirements are those required by law or regulation and they cannot be waived and are not subject to negotiation.

b. Proposals should be prepared simply and economically, providing a straightforward, concise and clear description of capabilities to satisfy

requirements of the RFP. Emphasis should be placed on completeness and clarity of content.

c. Proposals should be organized in the SAME order that the requirements are presented in the RFP. All pages of the proposal should be numbered. Each paragraph in the proposal should reference the paragraph number of the corresponding section of the RFP. It is also helpful to site the paragraph number, sub-letter, and repeat the text of the requirement as it appears in the RFP. If a response covers more than one page, the paragraph number and subletter should be repeated at the top of the next page. The proposal should contain a table of contents, which cross-references the RFP requirements. Information which the offeror desires to present that does not fall within any of the requirement of the RFP should be inserted at an appropriate place or attached at the end of the proposal and designated as additional material. Proposals that are not organized in this manner risk elimination from consideration if the evaluators are unable to locate where the RFP requirements are specifically addressed.

d. Each copy of the proposal should be bound or contained in a single volume where practical. All documentation submitted with the proposal should be contained in that single volume.

e. Ownership of all data, materials, and documentation originating and prepared for the State pursuant to the RFP shall belong exclusively to the State and be subject to public inspection in accordance with the Virginia Freedom of Information Act. Trade secrets or proprietary information submitted by an offeror shall not be subject to public disclosure under the Virginia Freedom of Information Act; however, the offeror must invoke the protection of Section 11-52D of the *Code of Virginia*, in writing, either before or at the time the data is submitted. The written notice must specifically identify the data or materials to be protected and state the reasons why protection is necessary. The proprietary or trade secret material submitted must be identified by some distinct method such as highlighting or underlining and must indicate only the specific words, figures or paragraphs that constitute trade secrets or proprietary information. The classification of the entire proposal document, line item prices and or total proposal prices as proprietary or trade secrets is not acceptable and will result in rejection and return of the proposal.

f. The signed proposal should be returned in an envelope or package, sealed and identified as follows:

From _____	09/08/04	3:00 p.m.
Name of Offeror	Due Date	Time

_____	High Risk Youth & Adults
Street or Box Number	RFP Name
_____	601-611-45417-05-HRY
City, State, Zip Code	RFP#

The envelope should be addressed as directed on page 1 of this solicitation.

If a proposal is not identified as required, the offeror takes the risk that the envelope may be inadvertently opened and the information compromised, which may cause the proposal to be disqualified. Proposals may be hand delivered to the designated location in the office issuing the solicitation. No other correspondence or other proposal should be place in the envelope.

3. **Oral Presentation**: Offerors who submit a proposal in response to this RFP may be required to give an oral presentation of the proposal to the Virginia Department of Health. This is a fact finding and explanation session only and does not include negotiation. The issuing state agency will schedule the time and location of these presentations. Oral presentations are an option of the purchasing agency and may or may not be conducted.

B. **Specific Requirements**: Proposals should be as thorough and detailed as possible, so that the Virginia Department of Health may properly evaluate your capabilities to provide the required services. Offerors are required to submit a written narrative statement including the following items as a complete proposal:

1. The return of the RFP Cover Sheet (pages 1 and 2) and addenda, if any, signed and filled out as required.

2. Completed Vendor Reference Sheet (Attachment 6) and other specific items or data requested in the RFP. The Vendor Reference Sheet should include VDH if the Offeror has held a contract with VDH within the past three years.

3. A written narrative to include:

a. A brief overview of the proposed project including a description of the population(s) targeted, methods/strategies to be used and evaluation method(s). Selection of the specific intervention(s) to be conducted should be justified through scientific evidence of effectiveness or theoretical approach. Plans to identify and provide services to persons with high-risk behaviors should be described. Offerors should also describe efforts to ensure that services will be provided in a culturally competent and linguistically appropriate manner. Input from target populations into the development of the

program should be documented. Mechanisms to refer individuals to other services should be described.

b. An overview of the Offeror's history and experience relevant to the scope of service and activities being proposed, including development and implementation of prevention education programs, support services and development of educational materials.

c. A description or list of all personnel who will be funded by or have responsibilities under this contract. Specify relevant professional degrees, training, work, volunteer or life experience and expertise in working with the identified target population. Résumés should be included as an attachment to the proposal. Job descriptions should be attached for any position, which the Offeror proposes funding under this contract, specifically showing the percentage of time requested for each position and how job activities relate to the attainment of objectives.

d. Assessment of need for the proposed activities through the use of epidemiological data, needs assessment surveys, and other data/markers. Unique community needs and issues should also be described. Offeror should verify that other resources are not available to provide the proposed services.

e. A comprehensive work plan identifying interventions to be conducted. The work plan should be described through specific, time-phased and measurable objectives. Process and outcome objectives, detailing action steps to be accomplished, should be included. The work plan must include an evaluation component.

f. Identification and description of all contracts/grants for HIV/STD prevention education and services that the Offeror currently provides.

g. Letters of agreement from all collaborating agencies or individuals detailing work to be performed by each party. Letters of support will not be accepted in lieu of letters of agreement.

h. A minimum of three letters of support detailing past or present collaboration of services.

i. Proposed budget for the January 1, 2005-December 31, 2005, time period. The budget must be submitted on the form provided. (Attachment 7).

j. A budget justification which details the budget line items, including a breakdown of personnel costs.

k. A completed Small, Women-Owned and Minority Businesses form. (Attachment 8)

VI. Evaluation and Award Criteria:

A. Evaluation Criteria: Proposal shall be evaluated by a review panel convened by the Department of Health using the following criteria:

Evaluation Criteria	Weight
1. Qualification and experience of Offeror and staff in providing HIV prevention services relevant to the Scope of Service. Qualification and expertise of agency personnel to effectively serve population (s) targeted including provision of services in a culturally competent and linguistically appropriate manner.	15
2. Specific plan or methodology to be used in performance of these services to include:	
a. Times, locations and methodology of service provision are appropriate and accessible to the population. The target population was included in the development of the intervention. The selection of the intervention is justified through scientific evidence of effectiveness or theoretical basis.	10
b. The demonstrated need for the proposed services.	15
c. Quality of the work plan and evaluation. Objectives are specific, measurable and time phased. Work plan includes both process and outcome objectives, with detailed action steps and a plan of evaluation. Project is feasible and sustainable. Strategies for identifying and providing services to persons with high-risk behaviors are documented.	30
d. Extent to which the Offeror demonstrates cooperation, collaboration and linkages to other services for the target population as evidenced by Letters of Agreement and Letters of Support.	15
3. Price/Cost Effectiveness	10
4. Participation of Small, Women-Owned and Minority Businesses	5
Total:	100

B. **Award Criteria:** Selection shall be made of one Offeror deemed to be fully qualified and best suited among those submitting proposals on the basis of the evaluation criteria included in the Request for Proposals, including price, if so stated in the RFP. Negotiations shall be conducted with the Offeror so selected. Price shall be considered, but need not be the sole determining factor. After negotiations have been conducted with the Offeror so selected, the agency shall select the Offeror, which in its opinion has made the best proposal, and shall award the contract to the Offeror. The Commonwealth reserves the right to make multiple awards as a result of this solicitation. The Commonwealth may cancel this Request for

Proposals or reject proposals at any time prior to an award, and is not required to furnish a statement of the reason why a particular proposal was not deemed to be the most advantageous. (Section 11-65D, *Code of Virginia*) Should the Commonwealth determine in writing and in its sole discretion that only one Offeror is fully qualified, or that one Offeror is clearly more highly qualified than the others under consideration, a contract may be negotiated and awarded to that Offeror. The award document will be a contract incorporating by reference all the requirements, terms and conditions of the solicitation and the contractor's proposal as negotiated.

VII. Optional Pre-Proposal Conference:

A pre-proposal conference will be held on August 24, 2004 at 11:00 a.m. at the Virginia Department of Health, James Madison Building, 109 Governor Street, Room 333. Offerors may also participate in this pre-proposal conference by phone. Audio participants should dial in between 10:55 a.m. and 11:00 a.m. to 800-497-3932. Please enter 8013 when prompted for the passcode. A roll call of audio conference participants will be taken at the beginning and end of the conference in order to ensure all participant attendance is recorded.

The purpose of this conference is to allow potential Offerors an opportunity to present questions and obtain clarification relative to any facet of this solicitation. Questions may be faxed prior to the conference to (804) 864-8053.

VIII. General Terms and Conditions:

A. **Vendors Manual:** This solicitation is subject to the provisions of the Commonwealth of Virginia Vendor's Manual and any revisions thereto, which are hereby incorporated into this contract in their entirety. A copy of the manual is normally available for review at the purchasing office and, in addition, a copy also can be obtained by calling the Division of Purchasing and Supply at (804) 864-7524.

B. **Applicable Laws and Courts:** This solicitation and any resulting contract shall be governed in all respects by the laws of the Commonwealth of Virginia and any litigation with respect thereto shall be brought in the courts of the Commonwealth. The contractor shall comply with applicable federal, state and local laws and regulations.

C. **Anti-Discrimination**: By submitting and signing this proposal, the Offeror certifies to the Commonwealth that they will conform to the provisions of the Federal Civil Rights Act of 1964, as amended, as well as the Virginia Fair Employment Contracting Act of 1975, as amended, where applicable, the Virginians With Disabilities Act, the Americans With Disabilities Act and Section 11-51 of the *Virginia Public Procurement Act.* If the award is made to a faith-based

organization, the organization shall not discriminate against any recipient of goods, services, or disbursements made pursuant to the contract on the basis of the recipient's religion, religious belief, refusal to participate in a religious practice, or on the basis of race, age, color, gender or national origin and shall be subject to the same rules as other organizations that contract with public bodies to account for the use of the funds provided; however, if the faith-based organization segregates public funds into separate accounts, only the accounts and programs funded with public funds shall be subject to audit by the public body. (*Code of Virginia*, § 11-35.1E).

In every contract over $10,000 the provisions in 1. and 2. below apply:

1. During the performance of this contract, the Contractor agrees as follows:

a. The Contractor will not discriminate against any employee or applicant for employment because of race, religion, color, sex, national origin, age, disability, or any other basis prohibited by state law relating to discrimination in employment, except where there is a bona fide occupational qualification reasonably necessary to the normal operation of the Contractor. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this nondiscrimination clause.

b. The Contractor, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, will state that such Contractor is an equal opportunity employer.

c. Notices, advertisements and solicitations placed in accordance with federal laws, rules or regulations shall be deemed sufficient for the purpose of meeting the requirements of this section.

2. The Contractor will include the provisions of 1 above in every subcontract or purchase order over $10,000 so that the provisions will be binding upon each subcontractor or vendor.

D. **Ethics in Public Contracting:** By submitting their bids or proposals, Bidders or Offerors certify that their bids or proposals are made without collusion or fraud and that they have not offered or received any kickbacks or inducements from any other Bidder/Offeror, supplier, manufacturer or subcontractor in connection with their bid or proposal, and that they have not conferred on any public employee having official responsibility for this procurement transaction any payment, loan, subscription, advance, deposit of money, service or anything of more than nominal value, present or promised unless consideration of substantially equal or greater value was exchanged.

E. **Immigration Reform and Control Act of 1986:** By submitting their bids or proposals, the Bidders or Offeror certify that they do not and will not employ illegal alien workers or otherwise violate the provisions of the federal Immigration Reform and Control Act of 1986 during the performance of this contract.

F. **Debarment Status:** By submitting their bids or proposals, Bidders or Offeror certify that they are not currently debarred from submitting bids or proposals on contracts by any agency of the Commonwealth of Virginia, nor are they an agent of any person or entity that is currently debarred from submitting bids or proposals on contracts by any agency of the Commonwealth of Virginia.

G. **Anti-Trust:** By entering into a contract, the Contractor conveys, sells, assigns, and transfers to the Commonwealth of Virginia all rights, title and interest in and to all causes of the action it may now have or hereafter acquire under the antitrust laws of the United States and the Commonwealth of Virginia, relating to the particular goods or services purchased or acquired by the Commonwealth of Virginia under said contract.

H. **Mandatory use of State Form and Terms and Conditions:** Failure to submit a proposal on the official state form provided for that purpose may be a cause for rejection of the proposal. Modification of or additions to the General Terms and Conditions of the solicitation may be cause for rejection of the proposal; however, the Commonwealth reserves the right to decide, on a case by case basis, in its sole discretion, whether to reject such a proposal.

I. **Clarification of Terms:** If any prospective Bidder or Offeror has questions about the specifications or other solicitation documents, the prospective Bidder or Offeror should contact the buyer whose name appears on the face of the solicitation no later than five (5) working days before the due date. Any revisions to the solicitation will be made only by addendum issued by the buyer.

J. **Payment**:

1. To Prime Contractor:

   a. Invoices for items ordered, delivered and accepted shall be submitted by the Contractor directly to the payment address on the purchase order/contract. All invoices shall show the state contract number and/or purchase order number; social security number (for individual Offerors) or the federal employer identification number (for proprietorships, partnerships and corporations).

   b. Any payment terms requiring payment in less that 30 days will be regarded as requiring payment 30 days after invoice or delivery, whichever occurs last. This shall not affect offers or discounts in less than 30 days, however.

c. All goods or services provided under this contract or purchase order that are to be paid for with public funds shall be billed by the Contractor at the contract price, regardless of which public agency is being billed.

d. The following shall be deemed to be the date of payment: the date of postmark in all cases where payment is made by mail, or the date of offset when offset proceedings have been instituted as authorized under the Virginia Debt Collection Act.

e. Unreasonable Charges. Under certain emergency procurements and for most time and material purchases, final job costs cannot be accurately determined at the time orders are placed. In such cases, contractors should be put on notice that final payment in full is contingent on a determination of reasonableness with respect to all invoiced charges. Charges which appear to be unreasonable will be researched and challenged, and that portion of the invoice held in abeyance until a settlement can be reached. Upon determining that invoiced charges are not reasonable, the Commonwealth shall promptly notify the contractor, in writing, as to those charges which it considers unreasonable and the basis for the determination. A contractor may not institute legal action unless a settlement cannot be reached within thirty (30) days of notification. The provisions of this section do not relieve an agency of its prompt payment obligations with respect to those charges which are not in dispute (Code of Virginia, 11-69).

2. <u>To Subcontractors</u>:

a. A contractor awarded a contract under this solicitation is hereby obligated:

1) To pay the subcontractor(s) within seven (7) days of the contractor's receipt of payment from the Commonwealth for the proportionate share of the payment received for work performed by the subcontractor(s) under the contract; or

2) To notify the agency and the subcontractor(s), in writing, of the contractor's intention to withhold payment and the reason.

b. The Contractor is obligated to pay the subcontractor(s) interest at the rate of one percent per month (unless otherwise provided under the terms of the contract) on all amounts owed by the contractor that remain unpaid seven (7) days following receipt of payment from the Commonwealth, except for amounts withheld as stated in 2 above. The

date of mailing of any payment by U. S. Mail is deemed to be payment to the addressee. These provisions apply to each sub-tier contractor performing under the primary contract. A contractor's obligation to pay an interest charge to a subcontractor may not be construed to be an obligation of the Commonwealth.

K. **eVA Business-to-Government Vendor Registration:** The eVA Internet electronic procurement solution, web site portal www.eva.state.va.us, streamlines and automates government purchasing activities in the Commonwealth. The portal is the gateway for vendors to conduct business with state agencies and public bodies. All vendors desiring to provide goods and/or services to the Commonwealth shall participate in the eVA Internet e-procurement solution either through the eVA Basic Vendor Registration Service or eVA Premium Vendor Registration Service. All bidders or offerors must register in eVA; failure to register will result in the bid/proposal being rejected.

a. eVA Basic Vendor Registration Service: $25 Annual Fee plus a Transaction Fee of 1% per order received. The maximum transaction fee is $500 per order. eVA Basic Vendor Registration Service includes electronic order receipt, vendor catalog posting, on-line registration, and electronic bidding.

b. eVA Premium Vendor Registration Service: $200 Annual Fee plus a Transaction Fee of 1% per order received. The maximum transaction fee is $500 per order. eVA Premium Vendor Registration Service includes all benefits of the eVA Basic Vendor Registration Service plus automatic email or fax notification of solicitations and amendments, and ability to research historical procurement data, as they become available.

L. **Precedence of Terms**: Paragraphs A-K of these General Terms and Conditions shall apply in all instances. In the event there is a conflict between any of the other General Terms and Conditions and the Special Terms and Conditions in all the Solicitation, the Special Terms and Conditions shall apply.

M. **Qualifications of Bidders and Offerors:** The Commonwealth may make such reasonable investigations as deemed proper and necessary to determine the ability of the Offeror to perform the work/furnish the item(s) and the Offeror shall furnish to the Commonwealth all such information and data for this purpose as may be requested. The Commonwealth reserves the right to inspect Offeror's physical facilities prior to award to satisfy questions regarding the Offeror's capabilities. The Commonwealth further reserves the right to reject any Proposal if the evidence submitted by or investigations of such Offeror fails to satisfy the Commonwealth that such Offeror if properly qualified to carry out the obligations of the contract and to complete the work/furnish the item(s) contemplated therein.

N. **Testing and Inspection:** The Commonwealth reserves the right to conduct any test/inspection it may deem advisable to assure that supplies and services conform to the specification.

O. **Assignment of Contract:** A Contract shall not be assignable by the Contractor in whole or in part without the written consent of the Commonwealth.

P. **Changes to the Contract:** Changes can be made to the Contract in any one of the following ways:

1. The parties may agree in writing to modify the scope of the contract. An increase or decrease in the price of the contract resulting from such modification shall be agreed to by the parties as a part of their written agreement to modify the scope of the contract.

2. The Purchasing Agency may order changes within the general scope of the contract at any time by written notice to the Contractor. Changes within the scope of the contract include, but are not limited to, things such as services to be performed, the method of packing shipment, and the place of delivery or installation. The Contractor shall comply with the notices upon receipt. The Contractor shall be compensated for any additional cost incurred as the result of such order and shall give the Purchasing Agency a credit for any savings. Said compensation shall be determined by one of the following methods:

a. By mutual agreement between the parties in writing; or

b. By agreeing upon a unit price or using a unit price set forth in the contract, if the work to be done can be expressed in units, and the Contractor accounts for the number of units of work performed, subject to the Purchasing Agency's right to audit the Contractors records and/or to determine the correct number of units independently; or

c. By ordering the Contractor to proceed with the work and to keep a record of all costs incurred and savings realized. A mark up for overhead and profit may be allowed if provided by the contract. The same mark up shall be used for determining a decrease in price as the result of savings realized. The Contractor shall present the Purchasing Agency with all vouchers and records of expenses incurred and savings realized. The Purchasing Agency shall have the right to audit the records of the Contractor, as it deems necessary to determine cost of savings. Any claim for an adjustment in price under this provision must be asserted by written notice to the Purchasing Agency within thirty (30) days from the date of receipt of the written order from the Purchasing Agency. If the parties fail to agree on an amount of adjustment, the question of an increase or decrease in the contract price or time for performance shall be resolved in accordance with the procedures for resolving disputes provided by the Disputes Clause of this contract or, if there is none,

in accordance with the disputes provisions of the Commonwealth of Virginia's Vendor's Manual. Neither the existence of a claim nor a dispute resolution process, litigation nor any other provision of this contract shall excuse the contractor from promptly complying with the changes ordered by the Purchasing Agency or with the performance of the contract generally.

Q. **Default:** In case of failure to deliver goods or services in accordance with Contract Terms and Conditions, the Commonwealth, after due oral or written notice, may procure them from other sources and hold the Contractor responsible for any resulting additional purchase and administrative costs. This remedy shall be in addition to any other remedies, which the Commonwealth may have.

R. **Insurance:** By signing and submitting a bid or proposal under this solicitation, the Bidder or Offeror certifies that if awarded the contract, it will have the following insurance coverages at the time the contract is awarded if services are performed on state owned or state leased property. For construction contracts, if any subcontractors are involved, the subcontractor will have worker's compensation insurance in accordance with Section 11-46.3 and 65.2-800 et seq. of the *Code of Virginia*.

The Bidder or Offeror further certifies that the contractor and any subcontractors will maintain these insurance coverages during the entire term of the contract and that all insurance coverage will be provided by insurance companies authorized to sell insurance in Virginia by the Virginia State Corporation Commission.

Insurance Coverages and Limits Required:

1. Worker's Compensation – Statutory requirements and benefits; require that the Commonwealth of Virginia be added as an additional named insured on Contractor's policy.
2. Employers Liability - $100,000.
3. Commercial General Liability - $500,000 combined single limit. The Commonwealth of Virginia is to be named as an additional named insured with respect to the services being procured. These coverages are to include Products and Completed Operations Coverage.
4. Automobile Liability - $500,000 – Combined single limit.

S. **Announcement of Award:** Upon the award or the announcement of the decision to award a contract as a result of this solicitation, the purchasing agency will publicly post such notice on the website http://vbo.dgs.state.va.us/VBO/Docs/Attention.asp for a minimum of 10 days.

T. **Drug-Free Workplace:** During the performance of this contract, the contractor agrees to (i) provide a drug-free workplace for the contractor's employees; (ii) post in conspicuous places, available to employees and applicants for employment, a statement notifying employees that the unlawful manufacture, sale, distribution, dispensation, possession, or use of a controlled substance or marijuana is prohibited

in the contractor's workplace and specifying the actions that will be taken against employees for violations of such prohibition; (iii) state in all solicitations or advertisements for employees placed by or on behalf of the contractor that the contractor maintains a drug-free workplace; and (iv) include the provisions of the foregoing clauses in every subcontract or purchase order of over $10,000, so that the provisions will be binding upon each subcontractor or vendor.

For the purposes of this section, "drug-free workplace" means a site for the performance of work done in connection with a specific contract awarded to a contractor, the employees of whom are prohibited from engaging in the unlawful manufacture, sale, distribution, dispensation, possession or use of any controlled substance or marijuana during the performance of the contract.

U. **Nondiscrimination of Contractors:** A bidder, offeror, or contractor shall not be discriminated against in the solicitation or award of this contract because of race, religion, color, sex, national origin, age, or disability or against faith-based organizations. If the award of this contract is made to a faith-based organization and an individual, who applies for or receives goods, services, or disbursements provided pursuant to this contract objects to the religious character of the faith-based organization from which the individual receives or would receive the goods, services, or disbursements, the public body shall offer the individual, within a reasonable period of time after the date of his objection, access to equivalent goods, services, or disbursements from an alternative provider.

IX. Special Terms and Conditions:

A. **Availability of Funds**: It is understood and agreed between the parties herein that the agency shall be bound hereunder only to the extent of the funds available of which hereafter become available for the purpose of this agreement.

B. **Audit:** The Grantee shall comply with the audit and reporting requirements defined by the Federal Office of Management and Budget (OMB) Circular A-133 (Audits of State, Local Governments, and Non-Profit Organizations) as applicable.

In accordance with the above Circular, the Grantee shall, if grant funds expended are $300,000 or more in a year, have a single or program-specific financial statement audit conducted for that annual period in compliance with General Accounting Office audit standards. If grant funds expended are less that $300,000 for a year, the Grantee must meet the General Accounting Office audit standards and maintain financial records for such audit that are available for review or audit by appropriate officials of the granting Federal agency, Virginia Department of Health, and the General Accounting Office.

As a condition of receiving funds, the independent auditor shall have access to all records and financial statements as may be necessary under the circumstance; and, all

personnel costs allocated to any contract must be substantiated by individual records of staff time and effort (T & E) devoted to the contract. All audits are to be conducted within one year of the close of the grant fiscal year end in accordance with the Standards for Audit of Governmental Organizations, Programs, Activities, and Functions issued by the Comptroller General. The Grantee must submit its audit report and corrective action plan to the Virginia Department of Health, Attention: Casey W. Riley, within thirty (30) days after the completion of the audit report. Failure to provide an audit report within the specified time period or failure to complete corrective actions will be considered a breach in the terms of contract, and as such may lead to termination of the grant or discontinuation of future funding until such time as an audit report is provided.

C. **Award:** Reference Evaluation and Award Section VII.

D. **eVA Business-to-Government Contracts:** The eVA Internet electronic procurement solution, web site portal www.eva.state.va.us, streamlines and automates government purchasing activities in the Commonwealth. The portal is the gateway for vendors to conduct business with state agencies and public bodies. Failure to comply with the requirements in a. and b. below will be just cause for the Commonwealth to reject your bid/offer or terminate this contract for default. Vendors desiring to provide goods and/or services to the Commonwealth shall participate in the eVA Internet e-procurement solution and agree to comply with the following:

   a. Submit a fully executed American Management Systems, Inc., (AMS) Trading Partner Agreement, a copy of which can be accessed and downloaded from www.eva.state.va.us. AMS is the commonwealth's service provider to implement and host the eVA e-procurement solution.

   b. Provide an electronic catalog (price list) or index page catalog for items awarded under a term contract. The format of this electronic catalog shall conform to the eVA Catalog Interchange Format (CIF) Specification that can be accessed and downloaded from www.eva.state.va.us. Contractors should email Catalog or Index Page information to eva-catalog-manager@dgs.state.va.us.

E. **Cancellation of Contract:** The purchasing agency reserves the right to cancel and terminate any resulting contract, in part or in whole, without penalty, upon 30 days written notice to the Contractor. Any contract cancellation notice shall not relieve the Contractor of the obligation to deliver and/or perform on all outstanding orders prior to the effective date of cancellation. Contractor shall credit VDH for the applicable decrease in service. VDH reserves the right to add similar equipment/system at same contract rate or negotiated maintenance service under this contract. Contractor should provide pricing, the reasonable time required to obtain spare parts, and training for any product or service.

F. **Confidentiality (Commonwealth):** The Commonwealth agrees that neither it nor its employees, representatives, or agents shall knowingly divulge any proprietary information with respect to the operation of the software, the technology embodied therein, or any other trade secret or proprietary information related thereto, except as specifically authorized by the contractor in writing or as required by the Freedom of Information Act or similar law. It shall be the contractor's responsibility to fully comply with Section 11-52 D of the *Code of Virginia.* All trade secrets or proprietary information must be identified in writing or other tangible form and conspicuously labeled as proprietary either prior to or at the time of submission to the Commonwealth.

Confidentiality (Contractor): The contractor assures that information and data obtained as to personal facts and circumstances related to patients or clients will be collected and held confidential, during and following the term of this agreement, and will not be divulged without the individuals' and the agency's written consent. Any information to be disclosed, except to the agency, must be in summary, statistical, or other form which does not identify particular individuals. Contractors and their employees working on this project will be required to sign the Confidentiality statement in this solicitation.

G. **Identification of Bid/Proposal Envelope:** Reference Proposal Preparation and Submission Requirements Section VI.

H. **Indemnification:** The contractor agrees to indemnify, defend, and hold harmless the Commonwealth of Virginia, its officers, agents, and employees from any claims, damages, and actions of any kind or nature, whether at law or in equity, arising from or caused by the use of the materials, goods, or equipment furnished of any kind or nature by the contractor/any services of any kind or nature furnished by the contractor, provided that such liability is not attributable to the sole negligence of the using agency or to failure of the using agency to use the materials, goods, or equipment in the manner already and permanently described by the Contractor on the materials, good, or equipment delivered.

I. **Independent Contractor:** When providing the services specified under this contract the contractor shall not be deemed an employee or agency of the Virginia Department of Health. The contractor shall act as an independent contractor and is responsible for obtaining and maintaining appropriate liability insurance, payment of all FIC, State and Federal taxes, and complying with other similar requirements that are customary in the industry.

J. **Lobbying Costs**: Associated costs with lobbying efforts are not allowed under this contract and will not be reimbursed.

K. **Small Businesses and Businesses Owned by Women and Minorities Reporting:** Where it is practicable for any portion of the awarded contract to be subcontracted to

other suppliers, the contractor is encouraged to offer such business to minority and/or women-owned businesses. Names of firms may be available from the buyer and/or from the Division of Purchasing and Supply. When such business has been subcontracted to these firms and upon completion of the contract, the contractor agrees to furnish the purchasing office the following information: name of firm, phone number, total dollar amount subcontracted and type of product/service provided.

L. **Ownership of Intellectual Property:** All copyright and patent rights to all papers, reports, forms, materials, outreach and training efforts, creations, or inventions created or developed in the performance of this contract shall become the sole property of the Commonwealth. On request, the contractor shall promptly provide an acknowledgment or assignment in a tangible form satisfactory to the Commonwealth to evidence the Commonwealth's sole ownership of specifically identified intellectual property created or developed in the performance of the contract.

M. **Renewal of Contract**: This contract may be renewed by the Commonwealth for an additional one (1) twelve month period, within a reasonable time (approximately 90 days) prior to the expiration date, under the terms and conditions of the original contract except as stated below. If the Commonwealth elects to exercise the option to renew the contract for additional one year periods, the budget for the additional years may be renegotiated based on resubmitted budget figures, funds available, contractor performance for the most recent completed year, and other important factors. Budget increases of $10,000 or 25% of the original contract amount must be approved by the Office/Division Director and the Director or Assistant Director of the Division of Purchasing and General Services.

N. **Subcontracts:** No portion of the work shall be subcontracted without prior written consent of the purchasing agency. In the event that the contractor desires to subcontract some part of the work specified herein, the contractor shall furnish the purchasing agency the names, qualifications and experience of their proposed subcontractors. The contractor shall, however, remain fully liable and responsible for the work to be done by its subcontractor(s) and shall assure compliance with all requirements of the contract.

X. **Method of Payment**: The Contractor shall be paid on the basis of invoices submitted, completion of objectives, and submission of required reports. Failure by the Contractor to submit invoices within the prescribed time frame shall forfeit its right to payment from the Purchasing Agency. The Contractor shall submit monthly invoices with attached itemized statement of charges by the 10th day of the following month, citing the contract number assigned to the contract, to the following address:

Virginia Department of Health
Division of HIV/STD
ATTN: Casey W. Riley, Director
P.O. Box 2448, Room 326
Richmond, Virginia 23218-2448

Contractors may request start-up funds at the time of contract signature equal to $1/12^{th}$ of the total contract award. Request for final payment must be made no later than 30 days from the end of the contract in order to close out the federal grant.

XI. Attachments:

1. Virginia's HCPC Prioritized Interventions
2. Taxonomy of Virginia HIV Prevention Interventions
3. VDH Prevention Education Standards
4. Virginia HCPC 2003 Comprehensive Plan Target Populations
5. PEMS Technical Requirements
6. Vendor Reference Sheet
7. Proposed Budget Form
8. Small, Women-Owned and Minority Businesses Form

XII. Enclosures:

1. Virginia Department of Juvenile Justice Facility List

Attachment 1.

HIV Community Planning Committee
Prioritized Interventions

Persons Living with HIV/AIDS
Prevention Case Management
Individual Level Intervention
Group Level Intervention
HIV Counseling and Testing

Racial and Ethnic Minorities
Social Marketing
Intensive Street Outreach
Community Mobilization
Prevention Case Management
HIV Counseling and Testing
Individual Level Intervention
Group Level Intervention
Mass Media

Injecting Drug Users
Intensive Street Outreach
Prevention Case Management
Individual Level Intervention
HIV Counseling and Testing

Men who have Sex with Men
HIV Counseling and Testing
Community Mobilization
Group Level Intervention
Social Marketing
Prevention Case Management
Individual Level Intervention

Heterosexuals
Group Level Interventions
HIV Counseling and Testing
Social Marketing
Mass Media

Inmates
Prevention Case Management
Group Level Intervention
HIV Counseling and Testing
Individual Level Intervention

Youth
Intensive Street Outreach
Group Level Intervention
Social Marketing
HIV Counseling and Testing

Transgender
Group Level Intervention
HIV Counseling and Testing
Community Mobilization
Intensive Street Outreach
Individual Level Intervention
Prevention Case Management

Attachment 2.

Taxonomy of Virginia HIV Prevention Interventions

I. CATEGORY I: Counseling, Testing, Referral, Partner Counseling and Referral Services

- **A. Counseling and Testing**
- **B. Referral**
- **C. Partner Counseling and Referral Services**
- **D. Other**

CATEGORY II: Health Education/Risk Reduction

A. Individual Level Intervention (ILI) – Providing one-to-one, personalized education which includes formal/informal assessments and a skills building component. May include HIV/STD awareness, primary and secondary prevention education, and referral. These interventions also facilitate linkages to services in both clinic and community settings (e.g., substance abuse treatment settings) in support of behaviors and practices that prevent transmission of HIV, and they help make plans to obtain these services.

B. Prevention Case Management (PCM) – A client-centered HIV prevention activity with the fundamental goal of promoting the adoption and maintenance of HIV risk-reduction behaviors by clients with multiple complex problems and risk-reduction needs. PCM is indicated for persons having or likely to have difficulty initiating or sustaining practices that reduce or prevent HIV acquisition, transmission, or re-infection. As a hybrid of HIV risk-reduction counseling and traditional case management, PCM provides intensive, on-going, individualized prevention counseling, support, and service brokerage. This HIV prevention intervention addresses the relationship between HIV risk and other issues such as substance abuse, STD treatment, mental health, and social and cultural factors. Priority for PCM services should be given to HIV seropositive persons.

C. Group Level Intervention (GLI) - Providing education to two or more individuals in a group setting which includes formal/informal assessments and a skills building component. May include HIV/STD awareness, primary and secondary prevention education, and referral. Health education and risk reduction intervention shifts the delivery of service from individual to groups of varying sizes. Group level education does not include "one-shot" educational presentations or lectures that lack a skills building component.

D. Community Level Intervention - *A distinct class of programs characterized by their scope of objectives. A community level intervention is designed to reach a defined community (may be geographic or an identified subgroup) with the intention of altering social norms in that community as a way to influence at risk behavior. A community level intervention may include aspects of other categories, but the combination must be aimed explicitly at community norms in order to be classified as a community-level intervention. Community level interventions seek to improve the risk conditions and behaviors in a community*

through a focus on the community as a whole, rather than by intervening with individuals or small groups. This is often done by attempting to alter social norms, policies, or characteristics of the environment.

E. Street and Community Outreach – The screening and engaging of individuals for the purpose of delivering primary/secondary prevention education, materials and/or referrals, usually within a specified location and/or community.

i. **Basic Street/Community Outreach** – Consists primarily of contacts during which outreach workers engage in brief conversations, providing information, literature, condoms, referrals, etc. This type of outreach is important for establishing rapport within a community and building trust with individuals. It can be used as a method for bringing clients into other services such as intensive street outreach, counseling and testing, prevention case management, home health parties, and peer education groups. Basic outreach can not be expected to change behaviors in and of itself and should not be considered an intervention.

ii. **Intensive Street/Community Outreach –** Includes ongoing encounters in which outreach workers spend extended periods of time with clients, assess risks, make plans with clients for behavior change, and provide referrals. The outreach worker and client meet on multiple occasions. Outreach workers may also facilitate clients' entrance into services and should verity follow-though on referrals when possible. Both process and outcome evaluation should be used in assessing this type of outreach. (The conditions of Basic Outreach must be met.)

iii. **Collaborative Street/Community Outreach** – An outreach effort that utilizes outreach workers from various agencies and other health care providers to participate in a tabling or stroll of an already identified and assessed area for the purpose of saturating the area with specific information, (e.g. a major syphilis outbreak has occurred in a residential area, the health department will be providing on-site testing, outreach workers would then be pivotal in disseminating information and directions about the testing. Collaborative outreach is a strategy or method for conducting basic and/or intensive outreach and should not be considered an intervention.

CATEGORY III: Health Communication/Public Information – The delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences to build general support for safe behaviors, support personal risk-reduction efforts, and/or inform persons at risk for infection how to obtain services.

A. Presentations/Lectures – These are information-only activities conducted in group settings; often called "one-shot" or "AIDS 101" education interventions.

B. Health/Community Fairs – To set up information tables or booths which may include interactive activities for the purpose of disseminating information verbally and written to the

general public and/or high-risk populations. Health/community fairs raise awareness and assist in building relationship within a community. May be used as a vehicle to recruit persons for other services/programs.

C. Mass Media – Use of the media to reach the public or targeted populations. (Includes television, radio, print, and the internet.) The use of print, radio, television or the internet to advertise an event or agency should not be considered a mass media campaign.

D. Hotlines – Interactive electronic outreach systems using telephones, computers and mail to provide a responsive information service to the general public as well as high-risk populations.

E. Clearinghouse – Interactive electronic outreach systems using telephones, mail, and the internet to provide a responsive information service to the general public as well as high-risk populations.

F. Social Marketing – social marketing is a form of community-level intervention which uses techniques adapted from commercial marketing to identify specific audiences called segments, identify their perceived needs, and then construct a program of services, support and communication to meet those perceived needs.

Revised 9/23/03

Attachment 3.

Virginia Department of Health
Division of HIV, STD, and Prevention Services
Prevention Education Standards

HIV Educator Standards

1. HIV educators should receive a minimum of four hours of training on a quarterly basis in one or more of the following areas: HIV/AIDS including clinical issues, sexually transmitted diseases, counseling and testing procedures and laws, tuberculosis, viral hepatitis, human sexuality, reproductive health and birth control, substance abuse, mental health, racism, cultural sensitivity, classism and homophobia. Employers shall document training(s) in employment records.

2. HIV educators should understand the basics of behavioral science theory.

3. HIV educators should have counseling and facilitation skills.

4. HIV educators should be able to conduct a sexual and drug use history and risk assessment and help clients develop a risk reduction plan.

5. HIV educators' dress, demeanor and communication skills should be appropriate to the situation and program participants.

6. HIV educators should not engage in inappropriate or sexual relationships with program participants.

7. HIV educators should be able to refer participants to clinical care, drug treatment and other community services.

8. HIV educators should have appropriate formal education, and/or practical knowledge and experience, adequate to perform expected duties.

Counseling and Testing Standards

1. Curricula for prevention counseling should address cultural diversity/specificity issues as the affect HIV counseling and testing.

2. All persons who provide HIV prevention counseling should complete the two-day CDC prevention counseling course offered by VDH through the HIV Resource and Consultation Centers or other health department personnel.

3. Health department personnel should be involved in providing some components of the

prevention counseling course.

4. Program reviews with health districts should include verification that skills inventories of health counselors have taken place as recommended.

5. Any site conducting counseling and testing utilizing VDH funds should adhere to the standards established by the CDC and any additional guidance or standards prescribed by VDH.

6. Program reviews with health districts should include assessment of implementation of both CDC and VDH standards.

Street and Community Outreach Standards

In setting standards for this activity, it is important to define terminology. The following definitions are described in Planning and Conducting Street Outreach Process Evaluation from the Centers for Disease Control and Prevention, U.S. Public Health Service.

Active Street Outreach: Outreach specialists moving down a street, screening and engaging prospective clients for the purposes of delivering information, materials and/or referrals. Active outreach is usually location specific, occurring within a few blocks radius or within a specific neighborhood.

Fixed Site Outreach: Outreach activities which are conducted at a specific place within a given location (e.g.) setting up a table on a corner or working out of a mobile van or storefront. During fixed site outreach, outreach specialists may invite persons whom they have engaged in the street to come to the site or place for more in depth assessment discussions and/or service delivery, based upon client needs or interests.

Drop Off Site Outreach: Outreach activities which provide risk reduction supplies to volunteer distributors who may then distribute these items to persons involved in risk behaviors (e.g.) brochures left at a check out counter or bleach kits distributed at an injection drug user "shooting gallery".

Contact: Face-to-face interaction during which materials and/or information is exchanged between an outreach specialist and a client (or a small group of clients).

Encounter: Face-to-face interactions that goes beyond the contact to include focused assessments, specific service delivery in response to the client's identified need(s), and a planned opportunity for follow-up.

The remaining terminology was developed by the Division of HIV/STD, its contractors, the VCU Survey and Evaluation Laboratory and the Virginia HIV Community Planning Committee.

Basic Street/Community Outreach: Consists primarily of contacts during which outreach specialist engage in brief conversations, providing information, literature, condoms, bleach kits, referrals, etc. This type of outreach is important for establishing rapport within a community and building trust with individuals. It can be used as a method for bringing clients into other services such as intensive street outreach, counseling and testing, prevention case management, home health parties, and peer education groups. Basic outreach can not be expected to change behaviors in and of itself and should not be considered an intervention.

Intensive Street/Community Outreach: Includes ongoing encounters in which outreach specialist spend extended periods of time with clients, assess risks, make plans with clients for behavior change, and provide referrals. The outreach specialist and client meet on multiple occasions. Outreach specialists may verify follow-up on referrals and bring individuals into other services. Both process and outcome evaluation should be used in assessing this type of outreach. (The conditions of Basic Outreach must be met.)

> **Collaborative Street Outreach:** An outreach effort that utilizes outreach specialists from various agencies and other health care providers to participate in a tabling or stroll of an already identified and assessed area for the purpose of saturating the area with specific information, (e.g. a major syphilis outbreak has occurred in a residential area, the health department will be providing on-site testing, outreach specialists would then be pivotal in disseminating information and directions about the testing). Collaborative outreach is a strategy or method for conducting basic and/or intensive outreach and should not be considered an intervention.

Safety

1. Outreach should be conducted in pairs. Individuals should not go out alone.

2. Supervisors should be informed about the areas to be targeted each session.

3. Outreach specialists should carry personal identification, agency identification and clothing that identifies them as an outreach specialist or agency staff person.

4. Before beginning outreach activities, staff should familiarize themselves with local law enforcement. Staff should be introduced to police officers at muster so that police understand their role in the community and don't mistakenly identify outreach specialists as drug dealer's etc. Involvement with the police department through a liaison or training should be established.

5. Outreach specialists should never buy from or sell anything to street contacts.

6. Agencies should establish "no weapons" policy while staff are conducting outreach.

7. Agencies should establish a communications, tracking and/or emergency plan for street outreach specialists.

Qualifications

1. Outreach specialists with a history of substance abuse should have a minimum of two years sobriety. This avoids putting individuals in situations that could trigger old behaviors while they are vulnerable to relapse.

2. It is more important for outreach specialists to be skilled in counseling, cultural competency, substance use/abuse, and have the ability to develop rapport with clients than to be indigenous to the community or neighborhood or population being targeted.

Training

Outreach specialists should be provided with the same opportunities as other health educators for professional development and training.

1. Outreach specialist should receive training in the following areas: HIV, STD's, substance abuse, mental health issues, counseling skills, availability of local resources, values clarification, human sexuality and homophobia, behavioral science and the language of HIV prevention.

2. Agencies should establish support mechanisms for outreach specialist, especially those in recovery. A staff person or other professional resource should be identified for support and referral into relapse prevention, 12 Step or other programs.

3. Outreach supervisors should participate in training along with their staff in order to understand the nature of the outreach specialist role and be available to provide adequate professional support.

4. Outreach supervisors should share information about objectives and grants for which outreach is being conducted and educate staff about the types of data to be collected.

Group Level Intervention Standards

1. There should be a commonality or link between participants that identifies them as members of the group.

2. The intervention should target a specific behavior or behaviors.

3. The intervention should include a risk assessment and a skills building component.

4. The provider should obtain or develop a curriculum for the intervention that defines the goals and objectives of the program.

5. Ground rules addressing attendance, participation, honesty, trust and confidentiality should be established with the participants at the start of the intervention.

6. The intervention should be provided in an nonjudgmental manner, (e.g. a safe space).

7. To the extent possible, the physical environment should be accessible and acceptable to the population.

8. Multiple session group level interventions should include an evaluation component.

9. The curriculum selected should be appropriate for the culture and language of the participants.

10. Staff conducting group level interventions should be trained in group facilitation skills.

11. Agencies should strive to achieve cultural congruence between facilitator and participants when feasible. This may include any or all of the following: race, ethnicity, primary language, gender, HIV status etc.

Individual Level Intervention Standards

1. The intervention should be client driven.

2. The intervention should target a specific behavior.

3. The intervention should include a risk assessment and a skills building component.

4. The provider and client should develop an action plan or goal that identifies desired outcomes.

5. Client rights and responsibilities should be established prior to the start of the intervention (e.g. confidentiality).

6. The intervention should be provided in a nonjudgmental manner (i.e. a safe space).

7. To the extent possible, the physical environment should be accessible and acceptable to the individual.

8. Individual level interventions should include an evaluation component.

9. The plan developed should be appropriate for the culture and language of the client.

10. Staff conducting individual level interventions should be trained in counseling.

11. Agencies should strive to achieve cultural congruence between the facilitator and clients when feasible. This congruence may include the following: race, ethnicity, primary language, gender, HIV status, etc.

HIV/AIDS "101" Standards
Basic Information to be Covered

What are HIV and AIDS?

HIV-Human Immunodeficiency Virus
How the virus attacks the body and immune system
The role of the immune system and antibodies
Spectrum of Disease: Progression from HIV to AIDS
AIDS-Acquired Immunodeficiency Syndrome
Opportunistic Infections
Currently no cure or vaccine

Transmission

Most common body fluids that transmit HIV are: blood, semen, vaginal fluids and breast milk; any body fluid that contains visible blood
Perinatal transmission
Routes of transmission include:
Sharing needles/syringes
Unprotected vaginal, oral and anal sex
Receipt of infected blood, blood products, tissues or organs (very rare)

Myths and Misconceptions

Casual Contact: eating, drinking, air, toilet seats, attending school or working with someone who has HIV
Body fluids that do not transmit HIV: saliva, tears, sweat, urine
Mosquitoes
Low risk from blood transfusions
No risk from donating blood
Urban Legends (needles in phone booths, movie theater seats, gas pump handles
Welcome to the World of AIDS, semen/blood put in food at fast food restaurants)

Prevention

Abstinence from sex and drug use
Monogamous sexual relationship between two uninfected people
Sex that does not involve exchange of body fluids
Not sharing needles/syringes and other drug paraphernalia
Cleaning needles/syringes and other drug paraphernalia

Barrier sex: using condoms, dental dams and/or other barriers consistently and correctly
Not sharing sex toys
Cleaning sex toys
(Time permitting and depending on the audience, educators can demonstrate proper condom usage and/or needle/syringe cleaning)

Knowing Your Status

Antibody Testing: Elisa and Western Blot
Window period for antibody testing: 8-24 weeks, average 12 weeks
The difference between anonymous and confidential testing
HIV positive does not mean you have AIDS
Availability of treatment to slow disease progression
Importance of testing for pregnant women

Resources

Hotlines
Test Sites
Local Health Departments
Community Based Organizations
Web Sites

Questions and Answers

Standards for Prevention Case Management

Prevention Case Management (PCM) is a client-centered HIV prevention activity with the fundamental goal of promoting the adoption and maintenance of HIV risk-reduction behaviors by clients with multiple complex problems and risk-reduction needs. PCM is indicated for persons having or likely to have difficulty initiating or sustaining practices that reduce or prevent HIV acquisition, transmission, or re-infection. As a hybrid of HIV risk-reduction counseling and traditional case management, PCM provides intensive, on-going, individualized prevention counseling, support, and service brokerage. This HIV prevention intervention addresses the relationship between HIV risk and other issues such as substance abuse, STD treatment, mental health, and social and cultural factors. Priority for PCM services should be given to HIV seropositive persons.

<u>Client Recruitment and Engagement</u>

- Protocols for client engagement and related follow-up should be developed, such as requiring a minimum number of follow-up contacts within a specified time period.

<u>Screening and Assessment</u>

- PCM program staff should develop screening procedures to identify persons at highest risk for acquiring or transmitting HIV and who are appropriate for PCM.

- All persons screened for PCM, including those who are not considered to be appropriate clients for PCM, should be offered counseling by the prevention case manager (or other staff) and referrals relevant to their needs.
- Thorough and comprehensive assessment instrument(s) should be obtained or developed to assess HIV, STD, and substance abuse risks along with related medical and psychosocial needs.
- All PCM clients should participate in a thorough client-centered assessment of their HIV, STD, and substance abuse risks and their medical and psychosocial needs.
- Case managers must provide clients a copy of a voluntary informed consent document for signature at the time of assessment. This document must assure the client of confidentiality.

Development of a Client-Centered Prevention Plan

- For each PCM client, a written Prevention Plan must be developed, with client participation, which specifically defines HIV risk-reduction behavioral objectives and strategies for change.
- For persons living with HIV and receiving anti-retroviral or other drug therapies, the Prevention Plan should address issues of adherence.
- The Prevention Plan should address efforts to ensure that a PCM client is medically evaluated for STDs at regular intervals regardless of symptom status.
- For clients with substance abuse problems, the Prevention Plan should address referral to appropriate drug and/or alcohol treatment.
- Clients should sign-off on the mutually negotiated Prevention Plan to ensure their participation and commitment.
- Client files that include individual Prevention Plan must be maintained in a locked file cabinet to ensure confidentiality.

HIV Risk-Reduction Counseling

- Multiple-session one-on-one HIV risk-reduction counseling aimed at meeting identified behavioral objectives must be provided to all PCM clients. Sessions should be flexible to address the needs of the clients.
- Training and quality assurance for staff must be provided to ensure effective identification of HIV risk behaviors and appropriate application of risk-reduction strategies.
- Clients who are not aware of their HIV antibody status should receive information regarding the potential benefits of knowing their HIV serostatus.
- Clients should be provided education about the increased risk of HIV transmission associated with other STDs and about the prevention of STDs.
- PCM program staff should develop a protocol for assisting HIV seropositive clients in confidentiality notifying partners and referring them to PCM and/or counseling and testing services.
- For persons receiving treatment for opportunistic infections and/or anti-retroviral therapy (ies), counseling to support adherence to treatments/therapies should be provided.

Coordination of Services with Active Follow-Up

- Formal and informal agreements, such as memoranda of understanding, should be established with relevant service providers to ensure availability and access to key service referrals.
- A standardized written referral process for the PCM program should be established. A referral tracking system should be maintained.
- Communication with other providers about an individual client is dependent upon the obtainment of written, informed consent from the client.
- A mechanism to provide clients with emergency psychological or medical services should be established.

Monitoring and Reassessing Clients' Needs and Progress

- Prevention case managers must meet on a regular basis with clients to monitor their changing needs and their progress in meeting HIV behavioral risk-reduction objectives. Individual meetings with a client must be reflected in the client's confidential progress notes.
- A protocol should be established defining minimum, active efforts to retain clients. That protocol should specify when clients are to be made "inactive."

Discharge from PCM upon Attainment and Maintenance of Risk-Reduction Goals

- A protocol for client discharge must be established.

Staff Qualifications

- Suggested Minimum Qualifications: A bachelor's degree or extensive experience in a human-services-related field, such as social work, psychology, nursing, counseling, or health education; skilled in case management and assessment techniques; skill in counseling; ability to develop and maintain written documentation (case notes); skill in crisis intervention; knowledgeable of HIV risk behaviors, human sexuality, substance abuse, STDs, the target population, and HIV behavior change principles and strategies; and cultural and linguistic competence. Staff without degrees or extensive experience should receive supervision and guidance from a licensed professional.
- Staff must be provided written job descriptions and opportunities for regular constructive feedback. In addition, staff should be provided opportunities for regular training and development.
- All staff must be knowledgeable of confidentiality laws and agency confidentiality policies and procedures. PCM staff should have signed confidentiality agreements on file with their employer.

Coordination of PCM with Ryan White CARE Act Case Management

- A protocol for structuring relationships with Ryan White CARE Act case management providers should be established and should detail how to transfer and/or share clients.
- PCM should not duplicate Ryan White CARE Act case management for persons living with HIV, but PCM may be integrated into these services.

Quality Assurance

- Clear procedure and protocol manuals for the PCM program should be developed to ensure effective delivery of PCM services and minimum standards of care.
- Written quality assurance protocols should be developed and included in procedure and protocol manuals.
- Client PCM records must contain a copy of the voluntary informed consent document and the Prevention Plan showing the client's signature.

Standards for Ethical and Legal Issues

- **Confidentiality.** Organizations must have well-established policies and procedures for handling and maintaining HIV-related confidential information that conform to state and federal laws. These policies and procedures must ensure that strict confidentiality is maintained for all persons who are screened, assessed, and/or participate in PCM.
- **Voluntary and Informed Consent.** A client's participation must always be voluntary and with the client's informed consent. Documentation of voluntary informed consent must be maintained in the client's file. In addition, a client's informed consent in required before a prevention case manager may contact another provider serving that same client.
- **Harm Reduction.** PCM staff should utilize principles of harm reduction. Harm reduction is a set of practical strategies that reduce negative consequences of drug use or other risk behaviors, incorporating a spectrum of strategies from reducing risks to abstinence. Harm reduction strategies meet clients "where they're at," addressing conditions of use along with the use itself.
- **Cultural Competence.** Organizations must make every effort to uphold a high standard for cultural competence, that is, programs and services provided in a style and format respectful of the cultural norms, values, and traditions that are endorsed by community leaders and accepted by the target population. Cultural appropriateness and relevance are critical to the success of any HIV prevention activity.
- **Professional Ethics.** Organizations must make efforts to ensure that clients have received appropriate referrals and are adequately receiving needed services at the time of discharge (graduation).
- **Duty to Warn.** Organizations must be familiar with state and local procedures/requirements related to duty to warn other individuals at risk or in physical danger.

Attachment 4.

Virginia HCPC Comprehensive HIV Prevention Plan Target Populations

Populations by Rank

Persons living with HIV/AIDS
Racial/Ethnic Minorities
Injecting Drug Users
Men who have Sex with Men
Heterosexuals
Inmates
Youth

Populations of Special Interest (not prioritized)

Transgender persons
Homeless
Persons who sell or trade sex
Mentally ill/mentally retarded

Brief Descriptions of the Target Population

Below are the priority populations and accompanying descriptions. Subpopulations are not in any specific rank order and should be considered a guide to better targeting of the overarching population.

Persons with HIV/AIDS

Because these individuals are already infected with HIV, continuing risky behaviors potentially places themselves at risk for sexually transmitted diseases, possibly acquiring a different or resistant strain of HIV and may place others at risk for infection. The need to learn their HIV status, reduce risk behaviors and access early intervention services highlight the importance of both primary and secondary prevention for this population.

- **Sub-populations**

Sex Workers

Multiple sex partners, including those who do not want to use condoms, present a risk for acquiring STDs, re-infection with HIV and for transmitting HIV to their partners. It may be difficult to assist these individuals in leaving the sex trade if they have few alternatives for employment or are actively using drugs. Women

sex workers who are pregnant may risk transmitting the virus to their child. Transgender sex workers have typically had negative experiences in trying to access systems for health care and support. They may see themselves as having limited opportunities for mainstream employment due to their status.

Racial/Ethnic Minorities

Racial/ethnic minorities, specifically Blacks, constitute the largest population of people living with HIV. Lack of support from family, friends, and religious institutions as well as a lack of trust of the health care service delivery system makes these individuals vulnerable to hiding their disease and not accessing prevention, support and care services. Denial of illness may be high and socioeconomic factors may restrict assess to services. A lack of knowledge of public prevention and care services (especially the AIDS Drug Assistance Program) may lead to a fatalistic attitude that "nothing can be done" and result in increased risk-taking behaviors.

Persons in Denial and/or with other Psychosocial Issues

Fear, anger and the inability or unwillingness to accept a diagnosis of HIV infection may result in individuals being lost to follow up and care. These individuals may continue or increase HIV risk behaviors that can transmit the virus to others. Individuals with mental illness, little education or impaired cognitive functioning may lack the ability to understand what their HIV status means, especially if they have no outward signs or symptoms of illness. Non-compliance with medications can lead to the spread of drug resistant strains of HIV and harm to the client.

Racial/Ethnic Minorities

This category includes individuals whose race, ethnicity, or cultural background is distinctly different from the dominant race or culture. This population includes African Americans, Hispanics, Asian/Pacific Islanders, Native Americans, African immigrants and others. While there are many diverse populations within this category, what distinguishes them is the extent to which their language, cultural traits, and family patterns set them aside from the dominant culture.

- **Sub-populations**

African American substance abusers

Substance abuse has had devastating and far-reaching effects upon African American communities. Racism, poverty and lack of adequate public drug treatment slots have resulted in a disproportionate impact of alcohol and other drug use among African Americans. Because substance abuse may lead to

lowered inhibitions, impaired judgment or exchange of sex for drugs or money, risk of acquiring HIV is increased even without the sharing of injection equipment.

Recent immigrants

Virginia, especially Northern Virginia, is a destination for many immigrants including African immigrants. Over 150 languages have been identified as the primary language among Northern Virginia school age children. In some households, the adults do not speak English. Children often serve as interpreters, which is neither practical nor ethical in medical situations. In addition, migrant populations on the Eastern Shore and Northwestern region of the state pass through Virginia each year for apple picking and other agricultural work. In recent years, growing Hispanic communities have settled in Galax, Rockingham county and the Eastern Shore to work in the poultry processing industry. Language and cultural barriers, immigration concerns, and lack of knowledge of the service system prevent many immigrants from accessing prevention and care.

African American and Latino gatekeepers in faith communities

Churches and other faith institutions continue to serve as spiritual and cultural centers of many African American and Latino communities. Faith institutions offer a unique opportunity to educate individuals not reached through other methods of outreach or interventions. In addition, faith institutions can influence community norms and values around HIV, making systemic changes in adoption of risk reduction behaviors, testing, and entrance into care possible. The trust and buy-in of the gatekeepers (ministers, lay leaders etc.) is necessary to accessing these populations.

Injecting drug users (IDU)

Members of this population use drugs by method of injection, either currently or in the past. This population is not limited to opiate users, since other drugs, such as cocaine and methamphetamine are also injected. Because of the illicit nature of drug use and the particular risk that sharing needles and works presents, this population can be difficult to reach and to engage in ongoing intervention practices.

- **Sub-populations**

New injectors (injecting 1 year or less)

New injectors represent the greatest opportunity to intervene before the individual acquires HIV, hepatitis B or hepatitis C. Because these individuals are often initiated into injecting by an older, experienced user, they may be sharing works with people who have already acquired these infections. New injectors also have

not previously received prevention messages about reducing risks when shooting drugs.

Other substance users not in treatment

Although not IDU, other substance abusers such as crack cocaine users are at increased risk for HIV. Cracks and sores around and inside the mouth caused by hot crack pipes and increased rates of ulcerative and other sexually transmitted diseases from exchanging sex for drugs put these individuals at higher risk than the "general population". Because these individuals are often encountered in similar settings and areas as IDU, efforts to target these individuals can be incorporated into programs targeting IDU.

IDU in Aftercare

The need to support IDU in aftercare programs and assist them in maintaining abstinence from injecting or safer injecting behaviors is often overlooked. As these individuals return to the environments and communities in which they used drugs, prevention interventions should be provided to offer reinforcement and support.

Sex workers

IDU who support their drug habit by engaging in sex for money or drugs are at risk from both their sexual activity and drug use. This category overlaps with a population of special interest.

Men who have sex with men (MSM)

This population includes men who self-identify as "gay" or "bisexual," as well as those who do not so identify, but who engage in sexual activity with other men. The most salient factor within this population involves the way in which their sexual behavior sets them aside from the dominant sexual culture. In many ways, this results in the attachment of stigma that prevents these men from readily accessing services. Additionally, diverse interests and backgrounds bring MSM to identify with and participate in a variety of subcultures that may have limited cross reference.

- **Sub-populations**

Down Low Men

Down low men (men who engage in sex with other men but do not identify as gay or bisexual and may have a primary relationship with a woman) are invisible to each other and to providers of outreach and services making them difficult to reach. In routine work and life DL men are likely to associate with the dominant

social and sexual culture. Epidemiology suggests that DL men are a significant avenue for HIV transmission to heterosexual women. These men are unlikely to attend HIV prevention programs targeted to MSM.

Racial/Ethnic Minorities

Diverse cultural beliefs shape personal, family and social life that may help or hinder outreach, provision of services and acceptance or resistance to interventions. Cultural values mpact whether or not MSM are acknowledged and receive support. Culturally sensitive providers are vital, yet not widely available, to overcome social stigma and to enhance the capacity of the community to respond effectively.

Substance Abusers

Alcohol and other drugs are widely used and abused among MSM for many reasons including self-medication for depression, low self-esteem and as a way to lower inhibitions. Alcohol has been prominent in the dominant social culture of MSM at bars, clubs and parties. In certain subcultures, prevalence of multiple substance abuse is high, substance use coincides with sexual activity, and is often perceived as integral and important to the sexual encounter. Substance abuse may lead to a disregard of safer sex practices or a reduced ability to make sound judgments and negotiations. Few providers are aware of the substances being used by their clients and many MSM are not likely to discuss their use, abuse or request referrals to treatment. Therapeutic environments for substance abuse are often not sensitive to and sometimes hostile to MSM.

Young Men

Establishing self-identify and experimentation are aspects of youth. The spectrum of experimentation toward self-identity may be broad, producing bisexual, transgender and questioning behavior. Nonjudgmental and comprehensive education on these issues is rarely available. At the same time, the internet has provided access to helpful information while also providing the means for easy and risky opportunities to experiment with both sex and use of drugs and alcohol.

Heterosexual

This population includes both men and women who engage in sexual activity with members of the opposite sex. Epidemiological data has demonstrated conclusively that women are at increasing risk of HIV infection. Other research has suggested that this is due, at least in part, to power imbalances in the relationships between men and women. Some men, who identify as heterosexual, engage in sexual activity with men and women but do not identify as gay or bisexual. These men may only be reached through programs targeted to heterosexuals.

- **Sub-populations**

Persons with multiple sex partners

These individuals are at increased risk for a variety of STDs that may also facilitate HIV transmission. They may have an inability or reluctance to negotiate safer sex and not recognize the consequences of their sexual behavior. Self-esteem, image, and an inability to recognize triggers that lead to sexual encounters such as loneliness, use of alcohol or drugs etc. may contribute to their risk taking behaviors. Persons who practice serial monogamy may not recognize they are at risk.

Persons with STDs

Persons with an existing or untreated STD are at greater risk for STDs due to a compromised immune system and easy access for the virus to enter their bodies, especially among persons with genital ulcer diseases. Persons who present for treatment provide a strategic opportunity for intervention as they have sex without barrier protection and either the individual or a partner has had more than one sexual partner. Persons who have not accessed treatment need to be brought into STD services and offered counseling and testing for HIV.

Racial/Ethnic Minorities

Social economic disparities among Racial/ethnic minority populations may prohibit accessing of the health care service delivery system. Religious and cultural norms (especially among Latino and Asian Pacific Islanders) present barriers to open discussion about sexuality between men and women. In African American communities, being a teen mother can be seen as a status symbol. These girls often date older men and seek status and connection with the father. This cultural norm encourages risk-taking behavior. There is a stigma associated with men of color seeking HIV prevention services for fear of being labeled gay. Programs that target "heterosexual" men are important, as they may be the only venue for reaching bisexual men or men on the down low who would not participate in prevention programs for men who have sex with men.

Women Having Sex with IDUs

These women may not be aware of their HIV risk if their sex partner hides his drug use. They may have a false sense of security because they are having sex with one partner. If they are aware of their partners drug use, they may believe that he is cleaning his works or not sharing works. They may be reluctant to acknowledge their partners risk behavior due to the stigma attached in injecting drug use. In addition, these women may be unable to detect signs of relapse in a person who had stopped using.

Inmates

Individuals in this population are either currently incarcerated or are actively enrolled in the probation and parole systems. These individuals are at particular risk because the very behaviors that placed them in the criminal justice system often also places them at risk for HIV infection, and because they may engage in behaviors while incarcerated that place them at even higher risk. Their need for prevention services is heightened by their lack of access to such services due to constraints enforced by correctional systems.

- **Sub-populations**

Youth offenders

Youth, in general, are more sexually active, are vulnerable to peer pressure, and tend to be more willing to participate in experimental behaviors that place them at risk for HIV infection. Being incarcerated, these youth miss out on the HIV prevention education opportunities available in schools.

Recently Released (6 months)

Because of the lack of community support, inmates have particular difficulty transitioning back into their communities. The longer the incarceration, the more difficult the transition. Newly released inmates frequently become more sexually active and increase their drug use as a way of compensating for "lost time". Reaching individuals who have been released six months or less provides an opportunity to intervene with HIV prevention methods that cannot be implemented in jails and prisons because of institutional restrictions.

Substance Abusers

Due to the national war on drugs, the criminal justice system has experienced a tremendous increase in the incarceration of substance abusers. These individuals bring behavior patterns that place them at risk for HIV infection into the jail or prison setting. These behaviors include needle sharing and exchanging sex for drugs that they continue to practice while incarcerated. Incarcerated substance abusers have higher HIV seroprevalence than other inmates.

Women

Women are being incarcerated in higher and higher numbers, primarily for drug-related offenses. Incarcerated women have a higher HIV seroprevalence rate than do incarcerated men. Most post-release programs and services are designed for men, making them less appropriate or acceptable for women. Because of their relatively shorter sentences, many women released from jail and prison are of childbearing age. Prevention and care issues for these women combined with the need to prevent perinatal transmission make them a key target population.

Youth

This population includes all individuals roughly under the age of 25. While the primary segment of this population includes those under the age of majority, adolescent issues persist into the early 20s. In Virginia, one of the most salient factors of this population is the difficulty of reaching students, due to the need for parental approval in many cases and the lack of cooperation of schools to provide sexually related information to students.

- **Sub-populations**

Youth who engage in survival sex

Youth may engage in survival sex for a variety of reasons. They may be homeless, having run away from home or been forced to leave. Emotional, physical or sexual abuse and sex may be used to trade for food, a place to sleep for the night, or drugs. Adults taking advantage of their situation may coerce them into prostitution. Gang initiation may include being forced to have sex with other gang members. Transgender youth (MTF) may engage in survival sex because they do not possess or are unaware of their skills, or because they cannot get a job due to their appearance.

Substance abusers

Testing limitations and rebelling against parental authority, youth may take risks and experiment with drugs and alcohol. Youth may have easy access to these substances because of a family members use, lack of parental supervision or because of running or trafficking for dealers.

MSM

Young MSM do not receive specific HIV and STD relevant prevention messages through formal education settings. Homophobia and fear of being outed may lead them to have anonymous sexual encounters or they may engage in relationships with older men (someone outside of their social setting). Because they have had little opportunity to engage in dating and relationship rituals in which heterosexual youth participate, young MSM may not have the opportunity to develop communication and negotiation skills around sex.

Racial/Ethnic Minorities

The issues that affect adult members of these populations also affect youth. These factors include racism, lack of trust in the health care service delivery system, a fear of doctors, language barriers, a lack of cultural competency among prevention and care providers, religious and cultural barriers to the discussion of sexuality, reproductive health and HIV, and low socioeconomic status that can limit access to services. In some cultures, fathering a child or giving birth confers

status and attention. Young people may engage in unprotected sex to become parents. Other cultures place a high value on virginity, leading young people to engage in even riskier activities such as anal sex.

Transgender

Transgender is a term used to describe individuals who have persistent and significant discomfort with their assigned gender (White & Townsend, 1998). Transgender individuals were born biologically male or female, but live their lives to varying degrees as the opposite gender. A transsexual is a transgender individual who seeks genital reassignment surgery. Not all transgender individuals are seeking to "transition" through hormone therapy, aesthetic surgery or genital surgery; in fact, many do not. Survival sex, sharing needles to inject hormones, lack of sensitivity from providers that discourages transgendered persons from seeking heath care or prevention services, and low self-image that may increase sex and drug-related risk behaviors all contribute to heightened risk for HIV among these individuals.

Homeless

This population includes persons who are either permanently, temporarily or periodically without a residence or shelter. Homeless persons have proven to be difficult to reach for a whole host of vital services. Because of the very high prevalence of mental illness, substance abuse, and prostitution among the homeless, the risk of HIV infection is remarkably high. However, their lack of stability and the culture of the street make it most difficult to reach them.

Persons who sell or trade sex

This population includes both those individuals who market their sexual services for money or drugs (i.e., those who have been termed commercial sex workers) and those who may have sex with only one or a very few number of individuals in order to obtain a wide range of benefits. This latter group includes women or youth who feel compelled to have sex with someone who provides housing or food, for example. Because these individuals often feel at the mercy of the "purchasers" of their services, they engage in behaviors that place them at risk for HIV infection. Because of the illegal nature of the behavior, particularly of commercial sex workers, they often do not trust those who approach offering beneficial services.

Mentally ill/mentally retarded

Because of their illness or limited cognitive abilities, these individuals often lack the social skills necessary to negotiate sexual and other relationships in ways that maintain their safety from HIV infection. These individuals are also significantly more likely to be incarcerated when not receiving proper treatment, placing them in situations and settings they are ill equipped to negotiate.

Attachment 5.

Program Evaluation and Monitoring System
(PEMS) Technical Requirements

PEMS End user Requirements:

- Access to the Internet (ISDN or faster connection)
- Microsoft Internet Explorer 6.0
- Super VGA (800x600) or higher resolution monitor with 256 colors

For Optimal performance, the recommended minimum specifications are:

- Pentium III 1.0 GHz processor
- 256 MB RAM
- 20 GB Hard Drive

Attachment 6.

Vendor Reference Sheet

Note: The following information is required as part of your response to this solicitation.

1. QUALIFICATIONS: The vendor must have the capability and capacity in all respects to satisfy fully all of the contractual requirements.

2. YEARS IN BUSINESS: Indicate the length of time you have been in business providing this type of service:

_____Years _____ Months

3. Indicate below a listing of at least four (4) current or recent organizations for which your agency has provided similar services or collaborated with (preferably within the last year). VDH should be included as a reference for any contacts held within the past three years.

A.	Organization:	Contact
	Phone:	Fax:
	Project:	Email:
	Dates of Service:	
B.	Organization:	Contact
	Phone:	Fax:
	Project:	Email:
	Dates of Service:	
C.	Organization:	Contact
	Phone:	Fax:
	Project:	Email:
	Dates of Service:	
D.	Organization:	Contact
	Phone:	Fax:
	Project:	Email:
	Dates of Service:	

5. OTHER: For statistical purposes , is your firm considered to be a:

minority owned business?	Yes____ No____
a woman owned business?	Yes____ No____

I certify the accuracy of this information.

Signed:_____ Title:_____

Date:_____

Phone/fax/email:_____

Attachment 7.

Proposed Budget

TITLE: High Risk Youth & Adult Program

RFP: # 601-611-45417-05-HRY

OFFEROR: _____

Personnel: _____

Fringe: _____

Supplies: _____

Travel: _____

Contractual: _____

Equipment: _____

Other: _____

Total: _____

Signature of Offeror: _____

Date: _____

Attachment 8.

Participation in State Procurement Transactions

By

SMALL BUSINESSES AND BUSINESSES OWNED BY WOMEN AND MINORITIES

The following definitions will be used in completing the information required by one or more of the three categories of businesses contained in this Appendix as applicable to your firm: (1) Participation by Small Businesses: (2) Participation By Businesses Owned by Women: and (3) Participation by Businesses Owned by Minorities.

I. DEFINITIONS

Period is the specified 12-month period for which the information provided in this list is applicable and valid. The period will be specified as month and year.

Firm Name, Address and Phone Number is the name, address and business phone number of the small business, women-owned business or minority-owned business with which the Offeror has contracted or done business over the specified period or plans to involve on this contract, as applicable.

Contact Person is the name of the individual in the specified small business, women-owned business or minority owned business who would have knowledge of the specified contracting and would be able to validate the information provided in this list.

Type of Goods or Services is the specific goods or services the Offeror has contracted for from the specified small, women-owned or minority-owned business over the specified period of time or plans to use in the performance of this contract, as applicable. The Offeror will asterisk (*) those goods and services that are in the Offeror's primary business or industry.

Dollar Amount is the total dollar amount (in thousands of dollars) the Offeror has contracted for or has done business with the listed firm during the specified period or plans to use on this contract, as applicable.

% Total Company Expenditures for Goods and Services is calculated by dividing the dollar amount of business conducted or contracted for with the indicated firm over the specified period by the total expenditure of the Offeror over the specified period for goods and services.

% of Total Contract is calculated by dividing the estimated dollars planned for the indicated firm on this contract by the total Offeror estimated price of this contract.

1. PARTICIPATION BY SMALL BUSINESSES

A. Offeror certifies that it ( ) is, ( ) is not, a small business concern. For the purpose of this procurement, a small business is a concern, including its affiliates, which is independently owned and operated, is not dominant in the field of operation in which it is contracting and can further qualify under the criteria concerning number of employees, average annual receipts, or other criteria, as prescribed by the United States Small Business Administration.

B. List small businesses with which the Offeror has contracted or done business and dollar amounts spent with each of these businesses in the most recent 12-month period for which data are available. Offerors are encouraged to provide additional information and expand upon the following format:

PERIOD: From: _____ To: _____

FIRM NAME, ADDRESS AND PHONE NO., EMAIL	CONTACT PERSON	TYPE GOODS/SERVICES	DOLLAR AMOUNT	% TOTAL COMPANY EXPENDITURES FOR GOODS AND SERVICES

1. PARTICIPATION OF SMALL BUSINESSES (Continued)

C. Describe Offeror's plans to involve small businesses in the performance of this contract either as part of a joint venture, as a partnership, as subcontractors or as suppliers. Offerors are encouraged to provide additional information and expand upon the following format:

FIRM NAME, ADDRESS & PHONE NO., EMAIL	CONTACT PERSON	TYPE GOODS/ SERVICES	DOLLAR AMOUNTS	% OF TOTAL CONTRACT

2. PARTICIPATION BY BUSINESSES OWNED BY WOMEN

A. Offeror certifies that it ( ) is, ( ) is not, a women's business enterprise or women-owned business. For the purpose of this procurement, a women-owned business is a concern that is at least 51 percent owned by a woman or women who also control and operate it. In this context, "control" means exercising the power to make policy decisions, and "operate" means being actively involved in the day to day management.

B. List businesses owned by women with which the Offeror has contracted or done business and dollar amounts spent with each of these businesses in the most recent 12-month period for which data are available. Offerors are encouraged to provide additional information and expand upon the following format:

PERIOD: **From:** _____ **To:** _____

FIRM NAME, ADDRESS & PHONE NO., EMAIL	CONTACT PERSON	TYPE GOODS/ SERVICES	DOLLAR AMOUNTS	% TOTAL COMPANY EXPENDITURES FOR GOODS & SERVICES

2. PARTICIPATION BY BUSINESSES OWNED BY WOMEN
(Continued)

C. Describe Offeror's plans to involve businesses owned by women in the performance of this contract either as part of a joint venture, as a partnership, as subcontractors or as suppliers. Offerors are encouraged to provide additional information and expand upon the following format:

FIRM NAME, ADDRESS & PHONE NO., EMAIL	CONTACT PERSON	TYPE GOODS/ SERVICES	DOLLAR AMOUNT	% OF TOTAL CONTRACT

3. PARTICIPATION BY BUSINESSES OWNED BY MINORITIES

A. Offeror certifies that it ( ) is, ( ) is not, a minority business enterprise or minority-owned business. For the purpose of this procurement, a minority-owned business is a concern that is at least 51 percent owned and controlled by one or more socially and economically disadvantaged persons. Such disadvantage may arise from cultural, racial, chronic economic circumstances or background or other similar cause. Such persons include, but are not limited to, Blacks, Hispanic Americans, Asian Americans, American Indians, Eskimos, and Aleuts.

B. List businesses owned by minorities with which the Offeror has contracted or done business and dollar amounts spent with each of these businesses in the most recent 12-month period for which data are available. Offerors are encouraged to provide additional information and expand upon the following format:

PERIOD: From: _____ To: _____

FIRM NAME, ADDRESS AND PHONE NO., EMAIL	CONTACT PERSON	TYPE GOODS/ SERVICES	DOLLAR AMOUNTS	% OF TOTAL CONTRACT

3. PARTICIPATION BY BUSINESSES OWNED BY MINORITIES
(Continued)

C. Describe Offeror's plans to involve minority businesses in the performance of this contract either as part of a joint venture, as a partnership, as subcontractors or as suppliers. Offerors are encouraged to provide additional information and expand upon the following format:

FIRM NAME, ADDRESS & PHONE NO., EMAIL	CONTACT PERSON	TYPE GOODS/ SERVICES	DOLLAR AMOUNTS	% OF TOTAL CONTRACT